MOMS Physician

(PCAP contractor – enter Specialty Code 159 on claim)

Procedure Code	Description	Maximum Fee
59409	Vaginal delivery only (with or without episiotomy, and/or forceps); (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits *).	$883
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); (when only **inpatient** postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits.	883
59514	Cesarean delivery only; (when only inpatient postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits *).	883
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; (when only **inpatient** postpartum care is provided in addition to delivery, see appropriate HOSPITAL E/M code(s) for postpartum care visits)	883

NOTE: Inpatient hospital visits should **not** be billed with MOMS specialty code 159. Bill visits (E/M codes) on a separate claim with the appropriate physician specialty code (e.g. 089 – Obstetrics and Gynecology, or 050 – Family Practice).

Sample 2

MOMS PHYSICIAN – PCAP CONTRACTOR

MEDICAL ASSISTANCE HEALTH INSURANCE CLAIM FORM TITLE XIX PROGRAM

Category of Service	Specialty Code	ONLY TO BE USED TO ADJUST/VOID A ID CLAIM	CODE	ORIGINAL CLAIM REFERENCE NUMBER
0460	159		A 1 / V 2	

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name): Theresa Evans
2. PATIENT'S BIRTH DATE: 68
3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, City, State, Zip Code)
5. PATIENT'S SEX: MALE / FEMALE: X
5A. INSURED'S SEX: MALE / FEMALE
6. MEDICARE NUMBER
6A. MEDICAID NUMBER: AM62633T
5B. PATIENT'S TELEPHONE NUMBER: ( )
6B. PRIVATE INSURANCE NUMBER
GROUP NO. / RECIPROCITY NO.
5C. PATIENT'S EMPLOYER, OCCUPATION OR SCHOOL
7. PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER
8. INSURED'S EMPLOYER OR OCCUPATION
9. OTHER HEALTH INSURANCE COVERAGE - Enter Name of Policy Holder, Plan Name and Address, and Policy or Private Insurance Number
10. WAS CONDITION RELATED TO: PATIENT'S EMPLOYMENT / CRIME VICTIM / AUTO ACCIDENT / OTHER LIABILITY
11. INSURED'S ADDRESS (Street, City, State, Zip Code)
12. PATIENT'S OR AUTHORIZED SIGNATURE — DATE
13. INSURED'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION (REFER TO REVERSE BEFORE COMPLETING AND SIGNING)

14. DATE OF ONSET OF CONDITION
15. FIRST CONSULTED FOR CONDITION
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS: YES / NO
16A. EMERGENCY RELATED: YES / NO
17. DATE PATIENT MAY RETURN TO WORK
18. DATES OF DISABILITY: TOTAL / PARTIAL — FROM / TO
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
19A. ADDRESS (OR SIGNATURE SHF ONLY)
19B. TYP / 19C. IDENTIFICATION NUMBER
20. FOR SERVICES RELATED TO HOSPITALIZATION, GIVE HOSPITALIZATION DATES: ADMITTED / DISCHARGED
20A. NAME OF HOSPITAL
20B. SURGERY DATE / 20C. TYPE OF SURGERY
21. NAME OF FACILITY WHERE SERVICES RENDERED (if other than home or office)
21A. ADDRESS OF FACILITY
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE: YES / NO — LAB CHARGES
22A. SERVICE PROVIDER NAME
22B. Type / 22C. IDENTIFICATION NUMBER
22D. EPSDT C/THP / 22E. STERILIZATION ABORTION CODE: 0 / 22F. STATUS CODE
23. DIAGNOSIS OR NATURE OF ILLNESS. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN 24F BY REFERENCE TO NUMBERS 1, 2, 3 ETC. OR DX CODE
1.
2.
3.
23G. POSSIBLE DISABILITY: YES / NO X
23H. PHCP: YES / NO
23I. FAMILY PLANNING: YES / NO X
23A. PRIOR APPROVAL NUMBER / 23B. PAYMENT SOURCE CODE

24A. DATE OF SERVICE	24B. PLACE	24C. TYPE	24D. SOURCE CODE: PROCEDURE/ITEM	MOD.	MOD.	24E. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	24F. SOURCE CODE: DIAGNOSIS CODE	24G. DAYS OR UNITS	24H. CHARGES	24I.	24J.
07 17 02	3		59514			Cesarean Delivery Only	V22.1		$883 00		

24K. INPATIENT HOSPITAL VISITS: FROM / THROUGH — 24L. PROCEDURE CODE / 24M. MOD.

25. CERTIFICATION (I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

William Sanders MD

26. ACCEPT ASSIGNMENT: YES / NO
27. TOTAL CHARGE
28. AMOUNT PAID
29. BALANCE DUE
30. EMPLOYER IDENTIFICATION NUMBER / SOCIAL SECURITY NUMBER

William Sanders MD
200 River Road
Anytown, NY 12905

25A. PROVIDER IDENTIFICATION NUMBER: 01526333
25B. DATE SIGNED: 07 20 02
25C. MEDICAID GROUP IDENTIFICATION NUMBER
25D. LOCATOR CODE: 03
25E. SA/EXCP CODE
32A. MY FEE HAS BEEN PAID: YES / NO
TELEPHONE NUMBER ( ) EXT.
COUNTY OF SUBMITTAL
INVOICE NUMBER: 54461 5591
DO NOT WRITE IN THIS SPACE
OTHER REFERRING/ORDERING PROVIDER / CASE MANAGER ID

- **Cesarean delivery ONLY**